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ABSTRACT

The document results from part of the Policy Options Project which identified and analyzed policy issues related to the delivery of appropriate services to preschool handicapped children and their families in terms of the need for assuring appropriate services, the factors affecting such policies, and policy approaches for the implementation of appropriate early developmental programs. Chapter I dicusses the benefits of early intervention for handicapped children and their families in terms of child, family, societal, and economic values; and analyzes existing policies regarding their effectiveness in assuring early intervention. Among conclusions drawn from the literature review and policy analysis are that early intervention has been documented as beneficial to society and the number of handicapped preschoolers and families needing but not receiving appropriate services cannot be precisely determined at this time. Chapter II addrsses five major policy areas which influence the development of early intervention services: defining the population to be served, delineating the scope of the services to be provided, designating the service provider, determining the nature of the policy, and identifying funding and resource availability. Final recommendations are that a lead agency be established to coordinate services and develop a coordinated public awareness campaign, that the state should develop standardized data collection and grant application techniques and due process safeguards, and that the stage should enact mandatory early intervention legislation granting universal access to services. Appended are position statements and a chart of ages of eligibility. (SBH)

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POLICY OPTIONS RELATED TO THE PROVISION OF APPROPRIATE EARLY INTERVENTION SERVICES FOR VERY YOUNG EXCEPTIONAL CHILDREN AND THEIR FAMILIES

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October 1980

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INTRODUCTION

Research efforts over the last fifteen years have documented the many benefits of providing developmentally appropriate services to handicapped infants and preschool-aged children and their families. And yet, there are few state and no federal assurances that these children will receive such services.

Recent Congressional testimony and policy research findings indicate a serious need for the development of public policies at all levels of government which assure very young handicapped children and their families access to early intervention services. One of the most frequently raised issues to Congress has been the need to assure appropriate services to handicapped children below the age of six--the age for which services are currently mandated under P.L. 94-142, The Education For All Handicapped Children Act of 1975 (Insight, Vol. 10, No. 10, 1979). Congress, in its oversight responsibilities, has received testimony from parents and professionals documenting cases of unserved young children and other areas of concern related to the education of handicapped children (U.S. House of Representatives Subcommittee on Select Education, 1979). Alarming results due to the lack of assurance were also enumerated, especially the serious problem of early intervention programs being discontinued when funding is endangered.

Moreover, other Congressional testimony suggested that the Preschool Incentive Grant Program under P.L. 94-142, the primary federal policy attempting to provide such an assurance, may serve as a disincentive to states for the development of their own policies and programs (The Council for Exceptional Children, 1979). The Act permits states which have no preschool mandate of their own to serve preschoolers voluntarily. The Act serves as a mandate for states which have their own mandatory policies. However, while promising $300 per handicapped child aged three through five who is served, Congress has, in fact, appropriated for FY 1981 only approximately $100 per child. Such inadequate funding has created a disincentive to developing state mandates due to these factors:

- If a state policy mandates early services for any portion of the preschool-aged handicapped population, it must assure all rights and protections of P.L. 94-142 with only the aid of $100 in federal money currently appropriated; however,
- If a state does not have a preschool policy of their own, they must comply with the P.L. 94-142 provisions only for the number of preschool handicapped they choose to serve. Thus, it may appear to be beneficial not to have a state mandate.

In addition to the Congressional testimony, research substantiates the need for further policy development and supports the notion that P.L. 94-142 provisions may be a disincentive. For example, a comparison of 1980 state provisions, assuring appropriate services to the preschool-aged handicapped child, to 1973 state education agency policies, documents a negative trend. Fewer states now have preschool special education provisions in their education policies than before P.L. 94-142 was passed. In fact, many state education agencies that had such assurances in 1973 appear to have raised the ages of eligibility for special education (Insight, Vol. 11, No. 6, 1980) or moved agency responsibility.

In light of these facts, the Policy Options Project of The Council for Exceptional Children identified and analyzed policy issues related to the delivery of appropriate services to preschool-aged handicapped children and their families: (a) the need for assuring appropriate services; (b) the factors affecting such policies; and (c) policy approaches for the implementation of appropriate early developmental programs.

Chapter I discusses the value of and need for early intervention for handicapped children and their families, as well as describes current policies as they relate to early intervention. Chapter II analyzes five issues in the provision of preschool services--defining the population to be served; delineating the

scope of the services; designating the service provider(s); the effects of certain policy dimensions, i.e., mandatory provisions as compared to permissive provisions; and resource availability--and describes policy options which address each issue.

GLOSSARY

A glossary of selected terms used throughout this paper is presented to facilitate an understanding of the terms frequently used in the field of early childhood intervention.

The Population: This term refers to any portion of the population below age six and includes such terms as "very young children" and "preschool-aged children."

Early Programming: This term refers to programs designed to enhance the growth and development of exceptional children below age six, and includes such terms as "early intervention," "early education," "early developmental services," "preschool," and "early services."

Developmental: This term refers to a program model, the goal of which is to assess and improve the child's growth and skills, based upon sequential stages of normal child growth and development.

Comprehensive: This term refers to a program model which includes the availability of educational, health, allied health, and social services as needed by the individual child and his or her family.

"At Risk" Children: This term refers to children whose medical or environmental circumstances place them in danger of developing a handicapping condition and is used interchangeably with the term "high risk." Medically, "at risk" children include those who are premature, have a low birth weight, or who possess a medical condition which has been shown to frequently result in a handicap, if not treated at an early stage. Environmental conditions, which have been proven to increase the probability of creating handicapping conditions, include poor nutrition, lack of medical care, abuse or neglect, and economic disadvantaged. These "at risk" factors may be present prior to or after the birth of the child. Thus, some preventive programs address the "at risk" mother, rather than or in addition to the child.

Human Services Agency: This term refers to a state agency, other than the state education agency, which provides services to children and families. Such agencies include Mental Health/Mental Retardation, Children and Family Services, Social Services, or umbrella agencies, such as Human Resources.

Chapter I
ESTABLISHING THE NEED FOR POLICY

This section discusses the benefits of early intervention for handicapped children and their families in terms of child, family, societal and economic values. Secondly, existing policies are analyzed as to their effectiveness in assuring early intervention.

The Value of Early Services

As early as 1967, Congress embraced the philosophy of providing services to handicapped children and their families as early as possible to remediate or lessen the effects of a handicapping condition (P.L. 90-538). However, at that time, Congress also called for the study of the effectiveness of various methods of such early intervention. Through research and demonstration projects, such as the Handicapped Children's Early Education Project (HCEEP) (P.L. 90-538), evidence has been compiled as to the benefits of early intervention and the effectiveness of certain methods and models of service delivery.

Early intervention programs, which have been funded and validated as effective by the federal government, vary in several components. Some programs are designed for infants, others for toddlers and older preschoolers. Programs vary as to their primary teaching focus, whether attending to the child or the parent, e.g., training parents to teach the child. Another program variable is whether the service is delivered in the home or at a center. In addition, programs differ with respect to their target population--selected handicapping conditions versus a noncategorical approach, i.e., any child with a handicap or developmental delay may attend.

Services also vary depending on the population and scope of the program. Infant stimulation for profoundly handicapped babies may include stroking the skin, turning and positioning the infant, and talking to and holding the infant. Conversely, an early intervention program for moderately

handicapped four and five year olds may be comprised of speech and language therapy, physical therapy, preacademic readiness lessons, and group play. Such activities are often provided directly by the professional or by the parent after professional training. Regardless of the mode of service delivery, the importance of including the parent and family in the programming and the services, to the extent accepted by and appropriate for the family, has been well established.

Bristol and Bartel (1980), in reviewing the state of the art of early childhood programs for the developmentally disabled, advance the following minimum criteria for an exemplary early childhood program:

1. Multidisciplinary assessment
2. Coordination or integration of services among multiple service providers or a full range of comprehensive services delivered by a multidisciplinary staff of the program itself. Intervention or therapeutic services must be provided in at least two of three areas:
    A. Health
    B. Education
    C. Social Services
3. Individual treatment plan for each child
4. Involvement of consumers in planning and programming
5. Evidence of program effectiveness

Child Value. The literature has grown substantially in the past decade showing the effects of early intervention on the development of handicapped and high risk children. Early reports established the growth and learning rate in the first three or four years of life as the fastest period of human learning and development (Bloom, 1964; Hunt, 1961; Kirk, 1958). Thus, it was asserted that to provide a developmentally disadvantaged child early services during this period of rapid learning and development increases the possibility of remediating and habilitating or lessening the effects of the handicap.

More recently, data have been collected on the actual effects of providing special education and other early developmental services to very young handicapped infants and their parents (Moore, 1979; Stedman, 1977), as well as to high risk

children (Lazar, 1979; Weikart, Bond & McNeil, 1978). Repeatedly, these efforts document significant increases even in areas of development, such as intelligence as measured by standard tests that once were thought to be "fixed" at birth and not subject to environmental factors. Unexpected gains have been found in all areas of development--motor, language, social/emotional, cognitive, self help--as well as across all categories of handicapping conditions, including conditions which render children "at risk" of becoming handicapped. In fact, differences in learning between high risk infants participating in an early intervention program and those not in a program have been documented at as early an age as 18 months (Ramey and Smith, 1975). Moreover, it has been recently shown, that the more years retarded children spend in preschool programs, the more significant the gains (Moore, 1979).

We now have evidence that what Bloom (1964) and others postulated is indeed true--that if we intervene during this period of rapid development, we are more likely to enhance the handicapped child's development, than if we wait five or six years for traditional school age. In fact, postponing intervention may result in the development of secondary handicapping conditions, such as emotional disturbance (Garland, Stone, Swanson & Woodruff, 1980).

Family Value. Persons involved with delivering these early services to very young children have begun to document the value not only to the child, but to the whole family. Many reports have documented the stress that the American family often experiences--social isolation, economic insecurity, loss of extended family patterns, disintegration of marriage (Keniston, 1977), and there is evidence that the presence of a handicapped child often creates additional stress both for the parents and the siblings (Hayden, 1979). Further, premature or sick infants suffer an overrepresentative proportion of child abuse (Elmer and Craig, 1976). Preschool programs cite the benefits to parents in areas such as personal attitude about themselves and their child (Lillie, 1978), information and skill acquisition,

and release time that can be used for employment (Garland, et.al., 1980). As programs have evolved, the benefits for parents and siblings have taken a major position of importance.

Societal Value. The social value of providing early services is both short term and long term. The short term effects include a higher level of acceptance of handicapping conditions by the families and their immediate friends and relatives (Hess, Block, Costello, Knowles, and Largary, 1971) when they can see that the children can learn and develop skills previously not thought to be possible. Secondly, American society embraces the belief that all persons have a right to prosper and develop their own potential. Thus, reaching families and children under stress and providing aid is consistent with our social values.

The long term social effects may be one of the most important and pragmatic considerations for policy makers. However, because early intervention research is relatively new, data on long term effects have not been available with the exception of a few scattered efforts. Skeels (1942) instituted one of the earliest longitudinal studies. He found that institutionalized children, who received maternal-like attention, many years later evidenced positive developmental gains which were distinguishable from a matched control group. These early studies, in conjunction with the recent evidence that early intervention increases the possibility of latter academic gains and decreases the need for special education placement and grade retention, lead to the logical hypothesis that the earlier the intervention, (a) the less likely the child or adult will have to be institutionalized or be dependent upon costly specialized services, and (b) the more likely they will be able to acquire employable and community living skills.

Economic Value. From an analysis of the cost figures reported to the U.S. Office of Special Education by projects of the Handicapped Children's Early Education Program (HCEEP), the annual per pupil expenditure for these early intervention projects appears to be approximately $2,000 to $2,500, with a wide range

($1,080 to $4,822) (Swan, 1980 (a)). This compares with a fiscal year 1980 national annual per pupil expenditure of $2,060. These figures are consistent with the literature. The Texas consortium projects reported that pupil costs ranged from $2,124 to $3,048. The median cost for seven projects scattered throughout the country was $1,995 per child. All of these projects served the moderately to severely handicapped population (Garland, et.al., 1980).

There are many program variables contributing to the wide variation in per pupil costs found in the literature, including:

- available funds;
- the fiscal year of service as it related to inflation;
- ages and severity of handicapping conditions of the children;
- first year start-up costs vs. continuation funding;
- demonstration and dissemination project costs (i.e., HCEEP) vs. direct service costs;
- provision of educational services or other single services vs. comprehensiveness;
- use of parent and volunteer time; and
- length of service period, whether 9, 10, or 12 months.

While early intervention may be as costly as average public school expenditures, Conley (1973) has discussed the cost/benefit of improving the skills of mentally retarded persons so that (a) the chances of costly institutionalization are minimized and (b) the chances of gainful employment and return to society are increased. Weber, Foster, and Weikart (1978) report that the Ypsilanti Perry Preschool Project has significantly reduced the need for the children of the preschool program to receive special services or to be retained in grades later in their public school years. These later services are costly, and they report significant cost/benefit from the early intervention:

Three types of benefit were found:

1. A substantial portion of the total costs of the preschool project were recovered from savings which resulted because students who had preschool education required less costly forms of education as they progressed through school than comparable students who did not have preschool--they required less special education and no institutionalized care.
2. Students who had preschool education had higher projected lifetime earnings than students who did not have preschool education. (The lifetime earnings projections were based on the students' educational progress in school, family background, and IQ scores).
3. The value of a parent's time released as a result of the child attending preschool was considered an economic benefit. (p. ix)

Through a sophisticated cost/benefit analysis, Weber, Foster and Weikart (1978) found that the benefits of the preschool services of the High Scope Project outweighed the costs by 236 percent.

As Gallagher (1979) points out, much of the cost/benefit data relate to services for the moderately to severely handicapped child. The benefit of providing early programs to the profoundly handicapped population may require a different analysis, similar to those discussed earlier, i.e., child, family and social benefit, as opposed to academic gains or employment rate.

In addition to the data supporting the efficacy of early intervention services for very young handicapped children and their families, many professional groups and governmental agencies have taken steps to support the concept. Often this support is in the form of written policy or position statements. The following are examples of groups which have developed policy statements supporting early intervention.

- The Council for Exceptional Children
- The Division for Early Childhood of The Council for Exceptional Children
- INTER-ACT: The National Committee for Services to Very Young Children with Special Needs and their Families
- National Education Association
- The Federal Government:
  a. Education Department

b. Department of the Interior - Bureau of Indian Affairs

c. Department of Defense - Overseas Schools

Congress raised questions twelve years ago concerning the availability of data supporting the benefit and effectiveness of early intervention. The answers to these questions are now available. Now we are better able to evaluate the adequacy of our current policies relative to the established need to deliver early developmental services to very young handicapped children and their families.

The Effectiveness of Current Policies

In determining the effectiveness of current federal and state policies to assure that every handicapped preschooler and his/her family have access to early services we (a) attempted to determine the number of unserved preschool handicapped children, and (b) analyzed the extent to which early services are actually assured by current policies.

Numbers Served. One indicator of the effectiveness of the current state and federal policies is the availability of services to this group of children. How many children are there, and how many children are being served? While this is an important consideration, the documentation of the incidence of handicapped children is confounded by various factors, as stated by Bartel and Ogel (1980):

- The number of handicapped children depends in large part on the definition of 'handicapped.' The definition is currently controversial and therefore, is itself dependent upon political considerations.
- The Bureau of the Census has not previously enumerated handicaps. These data have been provided for in the 1980 census form.
- Estimates have been made on the basis of epidemiological studies.
- Through federal initiative, a special census is being conducted but, so far, the number of children found is less than half of the number expected on the basis of epidemiological studies.

Further, complicating efforts to determine the number of handicapped

children currently served nationwide, are factors such as the following:

- Children served by various programs are often counted more than once;
- Many programs have no national reporting requirements; and
- More than one definition is used for counting.

Attempts to determine what percentage of the preschool population is handicapped have varied according to the criteria used to make such determinations. Applying the federally recognized percentage of handicapped children in the school-aged population (P.L. 94-142) would indicate that the estimated percentage of handicapped preschoolers may be 12 percent. However, as Garland, et.al. (1980) points out, there may be a wide range. The argument has been made that, particularly for the birth through three age group, the 12 percent figure is inflated due to various factors. One such factor is the inability to detect certain conditions like speech and language disorders or emotional disturbance at such an early age. Hence, it is estimated that only 7.5 percent of the preschool-aged population may be determined to be handicapped. On the other hand, the argument has been made that the 12 percent figure for school age is too small for the preschool group. If one were to serve infants whose medical or environmental factors may indicate a high risk situation or who may be exhibiting signs of a possible handicapping condition, the percentage may be as high as 17 percent (Garland, et.al., 1980). Finally, using the Developmental Disabilities definition, which requires a handicapping condition that impedes life activities, a 3 percent incidence may be expected (Wiegerink, 1980). Using the 1977 Census figure of 15,339,000 children birth through five years of age nationally, these percentages represent 1.8 million, 1.2 million, 2.6 million and 460,000 handicapped children birth through five, respectively.

Finally, the problem in answering the question of how many of these handicapped young children need but are not receiving developmental services is

rendered insurmountable due to insufficient data on the availability of services. The largest child count available nationally of the number of preschool-aged children receiving appropriate services by more than one agency is that for the three through five year olds funded under P.L. 94-142. This number, 231,815 for 1979-80, represents children in programs including nonpublic schools, i.e., Head Start and private nonprofit, because the public schools are finding it cost/beneficial to contract with existing services. The actual percentage of all children needing and receiving services is, unfortunately, impossible to document because of the scattered nature of public services, the kinds of services they are providing, and the insufficient information on private services. However, few of the existing programs offer the handicapped child comprehensive services. Rather, they tend to be purely diagnostic, medical or educational, or consist of financial assistance to the family.

While it is difficult to assess the effectiveness of current policies by computing the number of children and families currently receiving appropriate services, the analysis of the policies themselves provides a clearer picture of need.

Existing Federal Policy. As noted above, there are several federal programs which either provide assistance to states and localities who choose to serve the preschool-aged handicapped population or attempt to provide an assurance of narrowly defined services. However, there is no federal policy which provides an assurance of comprehensive developmental services to all handicapped children below the age of six, and their families.

Programs such as HCEEP provide "seed" or start-up money to local projects with the intent that the local or state public sector, recognizing the value, will maintain the program after the federal grant period ends. This particular program has been unusually successful with 86 percent of the original 21

demonstration projects over the past ten years being continued by state or local resources (Swan, 1980 (b)).

Other federal programs providing assistance for services to preschool-aged handicapped children include Head Start, which has a mandate to make 10 percent of their services available to the handicapped, Maternal and Child Health through programs such as Crippled Children's Services, and the Social Security Administration through programs such as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for medicaid eligible children. Some states (Wisconsin, Vermont) are utilizing Title I of the Elementary and Secondary Education Act (ESEA), state-operated and state-supported program funds to deliver early intervention services. The Developmental Disabilities Act of 1978 also provides for early childhood programs. The Indian Education Act (P.L. 92-318) provides assistance for services targeted at the very young Indian handicapped child in public schools or tribally operated schools. Finally, the State Implementation Grant (SIG) program supplies funds to the state education agencies for various administrative activities such as statewide planning and child find.

Other federal policies which provide limited assurances are P.L. 94-142 and Section 504 of the Rehabilitation Act of 1973, P.L. 93-112. While there is no federal mandate to assure handicapped children of preschool age comprehensive developmental services, according to the governing regulations for P.L. 94-142, all states receiving funds under the Act must, at a minimum, assure that they:

- Have a goal of providing such services to all handicapped children birth through 21 (§121a.123); and
- Have child find procedures for locating all handicapped children birth through 21 (§121a.142, 128).

However, as stated in the P.L. 94-142 regulations, a participating state is required to provide preschool experiences only if their own policies provide such a mandate:

> §121a.122. Timelines and ages for free appropriate public education.
> (a) General. Each annual program plan must include in detail the policies and procedures which the State will undertake or has undertaken in order to insure that a free appropriate public education is available for all handicapped children aged three through eighteen within the State not later than September 1, 1980.
>
> (c) Exception. The requirement in paragraph (a) of this section does not apply to a State with respect to handicapped children aged three, four, five, eighteen, nineteen, twenty, or twenty-one to the extent that the requirement would be inconsistent with State law or practice, or the of any court, respecting public education for one or more of those age groups in the State. (See also §121a.300.)

Further, P.L. 94-142, through its Preschool Incentive Grant Program, provides an additional per child allotment for each three, four or five year old handicapped child served. However, this program is voluntary, and the state must apply for it. Thus, P.L. 94-142 provides an assurance of appropriate services only to those children who live in states that have their own mandate or who are voluntarily served under the preschool incentive program.

A federal policy aligned with the permissive nature of the P.L. 94-142 preschool provisions is Section 504. This policy prohibits discrimination on the basis of handicap in federally-assisted programs. Thus, preschool programs for the nonhandicapped that are federally assisted must be made available to "otherwise qualified" (34 CFR, Part 104, §84.3(k)) handicapped children. However, this provision provides an assurance to only a small portion of handicapped preschoolers, because such programs are available to only a small portion of the nonhandicapped preschool population.

Existing State Policy. States that have instituted early childhood handicapped policies have done so primarily through two methods of change: (1) simply lowering the school age for the handicapped and with it all governing rules and regulations, or (2) establishing a new authority with rules and regulations

specific to the preschool-aged handicapped population. However, there have been few such changes over the past decade.

The Policy Options Project (1980) recently compiled all state education policies as they relate to ages of eligibility for special education and related services (Appendix B). Forty-six (46) states were found to have provisions for the education of exceptional children below the age of six. Twenty-one (21) states mandate in at least one policy document that services are to be provided to some portion of the birth through five population. Sixteen (16) states specified that services are permissive or may be provided if the locality so chooses, and nine (9) states had conflicting policies. Eight (8) states, i.e., Hawaii, Iowa, Kentucky, Maryland, Michigan, Nebraska, South Dakota and Vermont, appear to authorize services from birth, depending upon interpretation of policy language, e.g., "under 20." Five (5) states have no preschool provisions.

To determine the impact of recent federal policy on state education policy, the recently compiled eligibility data were compared to 1973 figures (Insight, Vol. 11, No. 6, 1980). Fifty (50) states and the District of Columbia were analyzed. Of these, seven (7) states were eliminated as the data from the sources used were not comparable. Seven (7) state education agencies have lowered the eligible age for mandated preschool services, while twelve (12) states have raised the age of eligibility. Overall, this reduction of written state education policy supporting programs at the younger age ranges, represents a negative trend in early intervention programs. Whether the policy was shifted from education to another state agency, as in the case of the states of Wyoming and Wisconsin, was not analyzed.

Of particular interest are the changes in state policy regarding permissive ages of eligibility. Several states have changed their preschool policies from mandatory to permissive, while other states have expressly written in permissive age ranges where none previously existed. Table I displays the states that have

instituted a lower age for service eligibility than they had in 1973. Table II displays the information relative to those states that have raised the age of eligibility.

TABLE I
STATES THAT HAVE LOWERED THEIR STATUTORY MINIMUM AGE*

State	1973	1980
Iowa	5-21 (conditional to 24)	under 21
Maryland	6-18	birth through 20
Minnesota	4, 5, or 6-21	4-21 (lowered for MR** & ED**)
Missouri	6-21	5 and under 21 (P** below 5)
Nebraska	5-21	from diagnosis to 21
New Hampshire	4 or 5-21	3 to 21/C** (P 0-3)
West Virginia	6-21 (3-6 permissive)	between 5 and 23 (P 3-5)

*In addition, four states (Arkansas, Illinois, Louisiana, and North Dakota) added permissive language.
**MR = Mentally Retarded
ED = Emotionally Disturbed
P = Permissive
C = Completion

TABLE II
STATES THAT HAVE RAISED STATUTORY MINIMUM AGES

State	1973	1980
Arizona	5-21	6-21 (5 if K**)
Florida	from 3	from 5 (0-4 P**)
Georgia	3-18	6 to C** (5 if K; 0-4 P)
Idaho	to 21 (lower limit abolished by law)	5-21
Indiana	3-21	over 6 and under 18 (3-5 P; HI** from 6 months)
Kansas	birth-21 (conditional to 24)	6-21/C (5 if K)
Mississippi	birth-21	6 and under 21 (under 6 P)
Montana*	birth-25	between 3 and 21 inclusive (9/1/80) (0-2 P)
Nevada	3-21	5 or 6 and under 18
North Carolina	birth to adulthood	between 5 and 18 (under 5 P)
Ohio	5-21	6-18 (5 if K)
Wisconsin	birth-21	3 and under 21 (under 3 P)

*Montana policy varied according to handicap in 1973. The majority were eligible birth-25
**K = Kindergarten
P = Permissive
C = Completion
HI = Hearing Impaired

Summary

From the literature review and the analyses of current policy, the following conclusions can be drawn:

- Early intervention has been documented as beneficial to society;
- The number of handicapped preschoolers and families needing but not receiving appropriate services cannot be precisely determined at this time; and
- Current federal and state education policies do not assure the availability of appropriate early intervention services to all preschool-aged handicapped children and their families. In fact, there has been an overall reduction in such provisions.

The remainder of this paper discusses the issues or constraints that have influenced the development of policy assurances. In addition, policy options are discussed that may facilitate remediation of identified constraints.

Chapter II
POLICY AREAS WHICH DETERMINE THE EXTENT AND NATURE OF SERVICES

This section addresses five major policy areas that influence the development of early intervention services. The factors have been identified in the literature, as well as by an analysis of current policies and/or position statements from various organizations or government sectors. These particular factors influence the scope and feasibility of policy. Research indicates that issues related to these factors are serving to either enhance or impede the development of public policy governing the provision of services to very young handicapped children and their families. It is the intent of this chapter to describe these issues and to offer policy options which would facilitate a feasible treatment of the problems they pose to policy development. Inherent in all the policy options is the right of the family to refuse services.

The costs of instituting a public policy is understandably a primary concern to decision makers and taxpayers. Educational and other human services' costs have come under close scrutiny recently in the wake of "Proposition 13" and other tax reform efforts. It is not surprising, then, that policy makers are expressing concern about the cost of early intervention. In fact, federal policy makers in the mid-1960's were sympathetic, but attempted to be practical by requiring further study of the benefits of early childhood services to the handicapped before instituting policy. As documented in Chapter One, the study has yielded positive results. Why, then, have policies not been more rapidly developed?

Factors related to cost that have impeded policy development include a possible hesitance to extend downward to the preschool population all the rights and protections of P.L. 94-142. School officials recently reported to Congress the difficulty in meeting the mandate for the school-age population (U.S. House of Representatives Subcommittee on Select Education, 1979). Secondly, as unemploy-

ment increases and as evidenced by federal action to create a youth initiative, there may be a shifting in emphasis to the needs of youth and young adults. Therefore, it is imperative to examine various options for delivering early intervention services in order to minimize adding to the constraints and fiscal burdens already felt by the public sector.

The policy areas addressed in this paper are defining the population to be served, delineating the scope of the services to be provided, designating the service provider, the nature of the policy itself, i.e., whether permissive or mandatory, and funding and resource availability.

POLICY AREA 1: POPULATION

The population to benefit from the public policy must be specified in order to assure their identification and access to services and to prevent diluting services to unintended populations. Dimensions of the preschool-aged handicapped population that need to be specified through policy are:

- The definitions of handicapping conditions of children to be served; and
- The age at which children will be eligible to receive services.

Definitions. The definitions employed by states to identify children who need special services vary widely. Essentially, two approaches are used, a categorical approach or a noncategorical approach. There are several policy alternatives within the former. The main difference between the two approaches is that the categorical approach labels children according to terms that relate to etiology, prognosis or medical terminology, rather than to educational classification or services to be provided.

At the present time, funding is most frequently made available to states and districts via a categorical approach. Procedures to tie such aid to programs or services, rather than to children, i.e., the noncategorical approach, do exist. States, such as Vermont, Massachusetts and North Carolina, have successful

experience in using this approach. Washington state implemented a noncategorical approach for the 1980-81 school year. After field tests comparing a developmentally handicapped definition for preschool children with a categorical definition approach, Washington found no significant increase in the eligible population.

In addition to the handicapping category approach used, another aspect of the definitional issue of particular relevance for the below five population involves consideration of a potential rather than actual handicap in triggering services to be delivered. Many infants and young children find themselves in "high risk" situations or are found to be "at risk" of developing a handicapping condition. This terminology and classification is found throughout the literature pertaining to certain preventive and remedial program and research efforts. The "high risk" or "at risk" situations range from prenatal physiological and/or environmental factors, such as age and health of mother, genetic history, availability of adequate nutritional and medical resources, to postnatal factors, including all of these, as well as the health of the infant and ability of mother and family to provide adequate care and protection. Many of the research efforts in the effects of early intervention have been for the "high risk" group. The data of several projects was recently compiled and shows that early intervention programs can prevent later handicapping conditions or significantly lessen the effects of these "high risk" factors (Lazar, 1979). Additionally, this population may require fewer costly and specialized services than the seriously handicapped. Hence, the services to the "at risk" group of children may be the most cost beneficial.

The definitional policy decisions are related to the incidence of handicapping conditions and numbers of children to be served as well as the type of program to be delivered. In essence, the more restrictive the definition, the fewer the children to be served, and secondly, the severity of the handicapping conditions will dictate certain needed services. For instance, if a

Developmental Disabilities definition is utilized, the expected incidence may be as low as 3 percent of the total preschool population, however, these children possess conditions which require many specialized services. If, on the other hand, a handicapped as well as the "at risk" population is served, the incidence may be as high as 17 percent. Thus, each option has its own cost/benefit implications, as indicated in Figure 1.

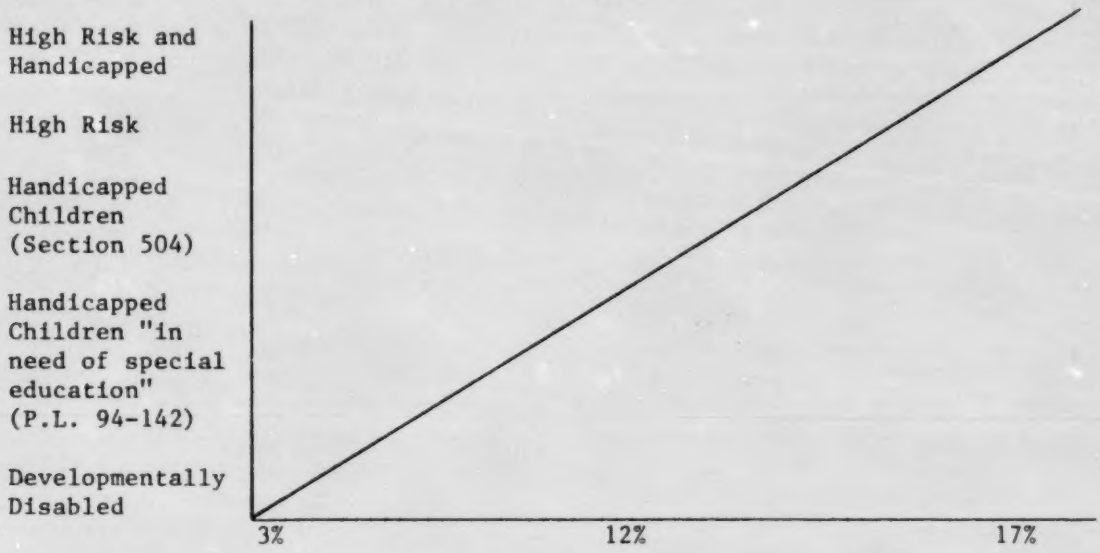

FIGURE 1. THE RELATIONSHIP BETWEEN CATEGORICAL DEFINITION AND POTENTIAL NUMBER OF CHILDREN SERVED

Ages of Eligibility. The second dimension of specifying the early childhood special education population is the age at which the young child is eligible to receive services. As previously noted, P.L. 94-142 assures services from age six unless a state policy makes such services available for younger children. The preschool incentive grant program provides a special allotment for the three through five year old group, and finally, states are encouraged to serve the birth through three group through provisions such as the requirement to locate and identify all handicapped children from birth through age 21.

Twenty-one (21) states presently mandate special education and related services to children below the age of five. Eight (8) states have at least one policy that appears to authorize services from birth. Some state policies,

rather than designating an age for eligibility criteria, establish a need criteria, e.g., Maryland's statute stipulates eligibility "as soon as the child can benefit."

TABLE I.

POLICY ALTERNATIVES FOR
DETERMINING THE POPULATION TO BE SERVED

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
POLICY AREA 1. POPULATION - DEFINITIONS	
OPTION 1.1 (CATEGORICAL): HANDICAPPED AS DEFINED BY P.L. 94-142 Handicapped children as defined according to P.L. 94-142 regulations: §121a.5 Handicapped children. (a) As used in this part, the term "handicapped children" means those children evaluated in accordance with §121a.530-121a.534 as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multi-handicapped, or as having specific learning disabilities, who because of those impairments need special education and related services. This definition establishes a two-pronged criterion for determining child eligibility under the Act. The first is whether the child actually has one or more of the disabilities listed in the above definition. The second is whether the child requires special education and related services. Not all children who have a disability require special education; many are able to and should attend school without any program modification (Ballard, 1977). Thus, the implications of this definition are that only those preschool-aged children who possess one or more of the conditions and require special education and related services are eligible under this definition.	POSITIVE ASPECTS OF OPTION 1.1 • Resources are limited to those who require specialized services in order to reach their potential rather than making them available to children who may benefit from nonspecialized services. • The public sector is acquainted with this definition with regard to school aged. NEGATIVE ASPECTS OF OPTION 1.1 • Difficulty of making the determination for a child in the preschool-aged group, particularly in the birth through three age group. • Categorical labels lack educational relevance since they relate to etiology rather than services needed.
OPTION 1.2 (CATEGORICAL): HANDICAPPED AS DEFINED BY SECTION 504 Handicapped children are defined according to Section 504: Any person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. Section 504 broadens the categorical classifications and removes the "by reason thereof" restriction of the P.L. 94-142 definition.	POSITIVE ASPECTS OF OPTION 1.2 • Eliminates the difficulty of determining whether a young handicapped child requires special services for optimum development, i.e., the P.L. 94-142 definition. NEGATIVE ASPECTS OF OPTION 1.2 • More children are assured services, therefore requiring greater resources.
OPTION 1.3 (CATEGORICAL): CONDITIONAL ELIGIBILITY Handicapped children in particular handicapping or severity categories will be assured services. Some states currently provide early childhood services for either certain conditions, e.g., hearing or visually impaired (Texas), or by severity, e.g., serious impairments (Massachusetts).	POSITIVE ASPECTS OF OPTION 1.3 • This option clearly limits the necessary resources, while providing early services to some children who are thought to have been shown to require intervention at an early age.

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
OPTION 1.4 (NONCATEGORICAL): DEVELOPMENTALLY DISABLED DEFINITION This policy defines the population as defined in the Developmental Disabilities Act (P.L. 95-602): The term "developmental disability" means a severe, chronic disability of a person which-- (A) is attributable to a mental or physical impairment or combination of mental and physical impairments; (B) is manifested before the person attains age twenty-two; (C) is likely to continue indefinitely; (D) results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and (E) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated. (§102(7))	NEGATIVE ASPECTS OF OPTION 1.3 • There are ethical and possible legal implications for conditional eligibility. The most apparent consideration is the arbitrary decision to assure needed services to some children while not providing similarly for other needy children. POSITIVE ASPECTS OF OPTION 1.4 • While maintaining a noncategorical or nonlabeling model, the Developmental Disability definition is restricted to those children whose impairment clearly impedes their life activities, thus defining a smaller incidence similar to P.L. 94-142. NEGATIVE ASPECTS OF OPTION 1.4 • The determination of impediment to life activities may be a difficult one for very young children and infants. • In restricting the population, the benefits to society are also limited, i.e., there will still remain a large percentage of children who will not benefit from early intervention.
OPTION 1.5 (NONCATEGORICAL): SPECIAL NEEDS The policy will define "children with special needs" rather than "handicapped children." Children with special needs are those who cannot adequately develop without special attention and services to meet their unique needs.	POSITIVE ASPECTS OF OPTION 1.5 • Depending on how such determinations are made, this approach is either as narrow as P.L. 94-142 or as broad as Section 504 and, therefore, assumes the qualities of those definitions. • The major strength is the avoidance of contributing a label. While the labeling issue has provided much controversy for the school-aged population, the opponents of labeling are more zealous in regard to labeling of birth through five year olds, because of the fear of the magnitude of the stigmatizing effect of a label on the young child's developing self-concept as well as the fear of mislabeling at such an early age. NEGATIVE ASPECTS OF OPTION 1.5 • Again, depending on the criteria for such determinations, either more resources will be needed or fewer children will be eligible for services.

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
OPTION 1.6 (NONCATEGORICAL): EXCEPTIONAL CHILD DEFINITION This definition includes both handicapped and gifted and talented children as eligible to receive early childhood special education and related services. Currently, 28 states utilize an exceptional child approach, and house handicapped and gifted programs together for administrative purposes for school-aged children (Zettel, 1978).	POSITIVE ASPECTS OF OPTION 1.6 • The similarities in identification procedures, procedural safeguards, personnel development policy and state and local management responsibilities between handicapped and gifted programs render the exceptional child approach both reasonable and efficient. Gifted Educators have expressed the benefits of early identification of gifted and talented as well as handicapped preschoolers (Karnes, 1980). NEGATIVE ASPECTS OF OPTION 1.6 • Greater resources will be required to serve a greater number of children if gifted children are included.
OPTION 1.7 (NONCATEGORICAL): THE "AT RISK" POPULATION The definition of handicapped children will include those children "at risk" of developing a handicapping condition. The "at risk" situation may be medical or environmental, or both.	POSITIVE ASPECTS OF OPTION 1.7 • Research shows that by including the "at risk" population, the policy will be helping to assure cost beneficial programs (Weber, et.al., 1978). • This provision allows for preventive services and programs to be implemented. • Services would be assured to the largest group of handicapped children with the affect of preventing many conditions. NEGATIVE ASPECTS OF OPTION 1.7 • By serving the "at risk" population, the financial commitment is greatest, albeit, theoretically, the return is greater. • Methods and criteria for determining eligibility are controversial. Parent judgment becomes a necessary determining factor in some cases.
POLICY AREA 1. POPULATION - AGES OF ELGIBILITY OPTION 1.8 THREE THROUGH FIVE YEARS OF AGE All handicapped children will be assured services from age three.	POSITIVE ASPECTS OF OPTION 1.8 • Providing services from age three establishes a policy for early intervention while limiting the population requiring those services. • Programs for the three through five year old population are usually less costly than for infants because of the types of services and the staff/child ratio needed which more closely resemble those for the school aged population. NEGATIVE ASPECTS OF OPTION 1.8 • The literature suggests that while intervention at age three is

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
	beneficial, it is more beneficial with the added aspects of prevention of some conditions if the programs are offered even earlier.
OPTION 1.9 BIRTH THROUGH THREE YEARS OF AGE Handicapped infants, birth through three years of age, will be assured services.	POSITIVE ASPECTS OF OPTION 1.9 • Allows for preventive as well as remedial programs, while at the same time limiting the population requiring resources. • This option may be cost beneficial in that the early intervention will most likely result in the prevention of some handicapping conditions. NEGATIVE ASPECTS OF OPTION 1.9 • There may be a failure to maintain the developmental gains between the age of three and the age the child becomes eligible for school, e.g., five or six. • There are ethical issues to terminating services for two or three years to families that have begun to rely on them. • Option 1.9 raises questions regarding the difficulty the child may experience in the transition from program to no program then eventually to school.
OPTION 1.10 BIRTH THROUGH FIVE YEARS OF AGE All handicapped children will be assured services from birth.	POSITIVE ASPECTS OF OPTION 1.10 • Assuring services from birth may be the most cost beneficial policy. • Preventive and remedial programs are offered with continuation through school age, helping to maintain benefits. • More children and their families benefit and the policy is equitable. NEGATIVE ASPECTS OF OPTION 1.10 • Providing assurances from birth is unquestionably the costliest option in terms of immediate expenditures simply due to the number of eligible children and families.
OPTION 1.11 ELIGIBILITY AT DIAGNOSIS All handicapped children will be assured services: (a) from time of diagnosis; or (b) as soon as he/she can benefit. Some states, rather than designating a specific age, assure services from time of diagnosis (Nebraska) or when they are determined to benefit (Maryland).	POSITIVE ASPECTS OF OPTION 1.11 • Services may be assured to children from birth without the need to specify such an assurance if politically unfeasible. NEGATIVE ASPECTS OF OPTION 1.11 • This option appears to lack the clarity that is needed to assure services to all handicapped children. Providers, as well as parents, may not be aware of what this policy does or does not authorize. • An "age of benefit" provision raises the issue regarding how to determine when the child will benefit from a program or services.

POLICY AREA 2: SCOPE OF SERVICES

A policy decision that must be made when planning early intervention programs is whether to simply extend a current school age mandate downward or whether new provisions tailored to the needs of the very young child and his/her family are required. The following options analyze possible effects of developing policies which (a) extend special education and related services provisions or free appropriate public education (FAPE) as defined by P.L. 94-142; or (b) maintain P.L. 94-142 provisions, but expand the allowable related services (FAPE +); or (c) develop a new policy tailored for the preschool-aged handicapped child and his/her family. As with all the policy areas, these options are not mutually exclusive nor discreet, but rather elements of each could be combined to create further options.

One decision that must be made by policy makers contemplating providing special education and related services to very young children and their families is the scope or comprehensiveness of such services. P.L. 94-142 regulations as well as most state policies define special education and related services as:

> (a)(1) As used in this part, the term "special education" means specially designed instruction, at no cost to the parent, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions (§121a.14)

> (a) As used in this part, the term "related services" means transportation and such developmental, corrective and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools and parent counseling and training. (§121a.13)

Thus, "related services" are integrally tied to the provision of special education.

Considerations with regard to adopting these definitions for the preschool-aged handicapped infant or child are:

- determination of what constitutes "special education" for the very young child, which not only determines the special education services but, if this two-step definition is adopted, also related services;
- determination of whether the existing list of related services is appropriate for the younger population or should be modified or expanded; and
- determination of whether the rights and protections, i.e., individualized education programs (IEP's), least restrictive environment (LRE) and due process, should be maintained for the preschool population.

For the purposes of this paper, the foregoing provisions are considered essential for a free appropriate public education: (FAPE) as defined by P.L. 94-142 regulations:

> As used in this part, the term "free appropriate public education" means special education and related services which:
> (a) Are provided at public expense, under public supervision and direction, and without charge,
> (b) Meet the standards of the State educational agency, including the requirements of this part,
> (c) Include preschool, elementary school or secondary school education in the State involved, and
> (d) Are provided in conformity with an individualized education program which meets the requirements under §§121a.340-121a.349 of Subpart C. (121a.4)

Secondly, the consideration to broaden the available services, i.e., adding medical and family services, but maintaining all other P.L. 94-142 provisions, is treated as "FAPE +." Both Interact and DEC have advanced the position that very young children and their families require services that go beyond the P.L. 94-142 definition of special education and related services. Particularly at issue are medical and developmental services and programs, and services often needed by parents and families who, upon discovering the fact that the child is handicapped, begin experiencing personal and financial stress. P.L. 94-142 includes

medical services (only those used for evaluative and diagnostic purposes) and does not authorize family services. However, it is the position of both groups that frequently if a handicapping condition is recognized at an early age, it is of significant severity to require medical attention. Secondly, particularly in the case of the birth through three age group or for any child whose handicapping condition is a result of trauma, illness or environmental factors, medical or other health services may help to prevent or remediate the problem.

A third consideration is whether to devise a definition of handicap and services that does not require a determination of the need for "specialized instruction" and would authorize any service needed by the child and family while not necessarily extending the provisions of P.L. 94-142. This option is considered "comprehensive -" for purposes of this paper and includes educational, medical, allied health and social services, but may delete certain rights and protections of P.L. 94-142.

And finally, "comprehensive +" would signify a policy that provides all services required by any eligible child and family and includes the rights and procedural safeguards of P.L. 94-142, such as individualized education program (IEP), least restrictive environment (LRE), and due process, but does not extend P.L. 94-142 administratively, i.e., is a new authority for preschool.

TABLE 2.
POLICY ALTERNATIVES FOR
DETERMINING SCOPE OF SERVICES

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
POLICY AREA 2. SCOPE OF SERVICES	
OPTION 2.1 FAPE All handicapped children will be assured free appropriate special education and related services as defined in P.L. 94-142.	POSITIVE ASPECTS OF OPTION 2.1 • The strength of providing FAPE lies in the current awareness, at least for those persons involved with special education, of what this term includes. • It clearly defines those services for which the public agency is responsible and through the two-step definition assures that services are required only for those children who need special instruction in order to benefit from education. • FAPE would essentially guarantee similar rights and services to preschoolers as are available to school-aged. • Many of the interagency agreements and cost sharing mechanisms developed for school-age services could be extended to the younger population. NEGATIVE ASPECTS OF OPTION 2.1 • Many persons concerned with the education of very young handicapped children believe that this population often requires services not included in these definitions, specifically medical and family services. • As currently defined, related services may only be delivered if it has been determined that the child requires special education. What "specially designed instruction" entails for a three month or three year old handicapped child may be a controversy which would have to be resolved before any services could be delivered. • If a child must be in need of special instruction, then there is already present a handicapping condition; therefore, preventive programs may be precluded. • This option may encounter resistance from persons hesitant to extend all P.L. 94-142 provisions, e.g., IEP, LRE, due process, because of administrative and financial burdens.
OPTION 2.2 FAPE + All handicapped children will be assured free appropriate special education and related services. Related services are defined as those required by P.L. 94-142 with the addition of medical and other allied health services and family services, such as parent and sibling training programs.	POSITIVE ASPECTS OF OPTION 2.2 • The strengths of this option lie in the ability to provide any service needed by the child or family to remediate the condition while also limiting the population to those requiring specialized instruction, as well as guaranteeing all rights and provisions of P.L. 94-142. NEGATIVE ASPECTS OF OPTION 2.2 • A weakness of this option is the constraints placed by the resources available to provide such comprehensive services.

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
	• The inability of various agencies to cooperate efficiently in delivering such diverse programs. • Preventive programs may not be authorized. • Resistance may be encountered to attempting to provide all rights and protections of P.L. 94-142.
OPTION 2.3 "COMPREHENSIVE -" All handicapped children and their families will be assured comprehensive services to meet their needs.	POSITIVE ASPECTS OF OPTION 2.3 • Comprehensive services would most likely result in the most significant developmental gains for the child and would provide the support services that would benefit all members of the family. • Alleviate the need to resolve the controversy of what constitutes special education for very young handicapped children and would allow for preventive services. Also, since this is not an extension of P.L. 94-142 (i.e., not FAPE or FAPE +), the determination must be made whether to extend all the rights of P.L. 94-142, i.e., IEP, LRE, due process, etc. • In the long run, this option may be most cost beneficial. NEGATIVE ASPECTS OF OPTION 2.3 • This alternative is one of the most costly. • It also opens a Pandoras box with regard to (a) whether to define the parameters of who is handicapped; (b) what services are required; and (c) how such determinations are to be made. • Establishes a need for determining whether to take advantage of existing procedures and structure established under P.L. 94-142. • If the decision were made not to include the rights guaranteed by P.L. 94-142 and Section 504, i.e., the IEP, LRE, etc., Congressional amendments would be required, because the laws now stipulate that such assurances be extended to <u>all</u> children served.
OPTION 2.4 "COMPREHENSIVE +" All handicapped children and their families will be assured comprehensive services to meet their individual needs, as outlined in a written individualized education program (IEP), and delivered in the least restrictive environment appropriate. All procedural safeguards, as found in P.L. 94-142, are applicable.	POSITIVE ASPECTS OF OPTION 2.4 • All needed services will be provided. • No designation of "in need of special education." • All procedural safeguards of P.L. 94-142 are extended without the administrative provisions, i.e., SEA responsibility, etc. • Option 2.4 is a new authority, therefore, can be tailored for the preschool population, while maintaining all the protections of P.L. 94-142. NEGATIVE ASPECTS OF OPTION 2.4 • Option 2.4 is the most costly.

POLICY AREA 3: SERVICE PROVIDER

P.L. 94-142 instituted a "sole state agency" provision which placed the responsibility for the education of handicapped children and youth with the State Education Agency (SEA). The legislative history of this provision documents the historical problems of children falling through the "cracks" between agencies, either because of the lack of clarity of responsibility or because of the effort to have the "burden" shared. However, the net result often was that nobody had responsibility. Thus, P.L. 94-142 regulations designate the SEA as the sole responsible agency, clarifying that this requirement does not mandate the SEA to provide or pay for the services, but rather to assure the provision of the services (§121a.301).

Some program providers, as well as some members of Congress, have questioned whether this SEA responsibility is appropriate for children under six years of age. Gallagher (1979) asserts that one of the difficulties in moving policy ahead at the state level is the dispute between the SEA's and the Departments of Human Resources or other state human services providers, as to the most appropriate provider. He advances the argument that such barriers would be eliminated "Solomon-like" by dividing the responsibilities--designating the birth to three group to the human services agency and the three through five age group to the SEA. His rationale includes the prospect that many services required by the birth to three handicapped child are often screening, diagnosis, health care, social services, i.e., services typically provided by human resources. Secondly, by the age of three, "we concern ourselves with the manner in which they will spend the next decade of their life--the school."

Currently, the major service providers are the education agencies, human services agencies, such as Mental Health/Mental Retardation and Social Services, and the private sector. According to the U.S. Office of Special Education, 86 percent of the original 21 handicapped early childhood demonstration projects

started with federal grants have been continued on state or local funds. Most of these projects have been continued by more than one agency, and the most often cited is the public schools (Swan, 1980 (b)).

A recent national survey addressing the question of agency responsibility for early intervention services for the birth to three group was conducted by Behr (1980). Questionnaires were mailed to 200 state agencies, advocacy and consumer groups and services providers within each state, territory and the District of Columbia, and 115 replies were received. The respondents were: State Directors of Special Education, State Directors of Mental Retardation, Early Childhood Consultants, State Implementation Grant (HCEEP) Coordinators, advocacy and consumer groups, and program providers. Strategies to be rank-ordered by preference included: state education agency (SEA) responsibility and provider through a downward extension of P.L. 94-142, SEA responsibility through a downward extension of P.L. 94-142 but with schools coordinating and contracting other service providers, expansion of the Handicapped Children's Early Education Program (HCEEP) (federal grant program), expansion of Head Start, local option to serve, and the creation of a new agency and authority.

Of the respondents, 52 percent preferred through an extension of P.L. 94-142 the public school responsibility and provider or coordinator and broker of services. Rationale for the choices are reported as including:

- "P.L. 94-142 provides a full-service goal to all handicapped children, 0-21. Services for handicapped children, 0-3, are in the broadest sense educational."
- "Programs could be coordinated and more effectively and efficiently administered under the auspices of one public system."
- "Historically, the public schools have been the only longitudinal publicly funded delivery system for handicapped children, and should remain as such."

- "Schools should not necessarily have to pay for services, but should be coordinating with other public and/or private agencies in order to avoid duplication of services. The SEA's and LEA's should plan and contract with other agencies for needed services. P.L. 94-142 assures protection of rights while leaving schools free to provide services through agencies that have the necessary expertise."

In addition to the public agency issue is the question of the role of the private sector. Historically, in many areas of the country, the only programs available to the under school-aged child was the small program in the basement of a church, administered by a private club or organization. Local Associations for Retarded Citizens (ARC), United Cerebral Palsy, Shriners and other civic groups have stepped in where the state was reluctant to go. In addition to day programs, the private sector has supplied many of the residential programs for all ages of the handicapped population. Finally, the private sector is regarded as more politically able to advocate for the needs of families and children. Consequently, where these programs currently exist, the related issues include: What will be their role when a public policy is developed? Will families have free choice? Will services be duplicated?

TABLE 3.
POLICY ALTERNATIVES FOR
DETERMINING SERVICE PROVIDER

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
POLICY AREA 3. SERVICE PROVIDER	
OPTION 3.1 STATE EDUCATION AGENCY RESPONSIBILITY The State Education Agency will assure the provision of appropriate services to all handicapped children from birth.	POSITIVE ASPECTS OF OPTION 3.1 • While the SEA's are already mandated by P.L. 94-142 to assure appropriate services to all school-aged handicapped children, they are also to conduct a statewide child find, birth through twenty-one, and report such data. • Child find may be enhanced by the very fact that every community has a school, but not every community has a social or human services agency or even a hospital. • This alternative also facilitates program consistency from birth through twenty-one and administrative ease of simply lowering all P.L. 94-142 procedures and provisions to cover the birth through five handicap population. NEGATIVE ASPECTS OF 3.1 • Few public school agencies have the trained personnel necessary to provide developmental services to preschool-aged handicapped children and their families, particularly for the birth through three age group. • Many school officials feel over-burdened with the mandate to provide services not historically considered within the realm of public schools for school-aged handicapped children. • Many of the services that may be required by this population have been considered in some states the responsibility of other agencies. • There are significant proportions of communities who fear the public schools perpetuate the evils of society. These groups are reluctant to bring very young children under the public school umbrella any earlier than necessary and may resist Option 3.1. The local control of Head Start was partially a result of this concern.
OPTION 3.2 HUMAN SERVICES AGENCY RESPONSIBILITY The Human Resources Agency will assure the provision of appropriate services to all handicapped children from birth to public school age.	POSITIVE ASPECTS OF OPTION 3.2 • Human resources agencies have taken a lead role in early intervention in many states. • In addition to direct service programs to children and families, some of these agencies are implementing preventive programs and historically have administered most programs for families. • In addition to these existing missions, which includes providing medically-oriented services which very young handicapped children often require, human resource agencies have a history of delivering interdisciplinary programming often required for early intervention.

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
	NEGATIVE ASPECTS OF OPTION 3.2 • While the human services mission in the area of the handicapped has often been medically, physiologically or disease oriented, the developmental or educational model has been proven to be effective through the early demonstration projects. There is no such evidence that medical models are effective in facilitating skill development. • Human resource programs are plagued by reports of inefficiency and unaccountable procedures, e.g., welfare scandals, medicaid/medicare abuses. • There is less visibility of these agencies in many communities than the local public school. In fact, many rural communities do not even have a hospital. • There is no prototype for delivering all appropriate services for this administrative structure like P.L. 94-142 is for education agencies.
OPTION 3.3 HUMAN SERVICES AGENCY RESPONSIBILITY FROM BIRTH TO THREE AND STATE EDUCATION RESPONSIBILITY FROM THREE THROUGH FIVE The Human Services Agency will assure the provision of appropriate services to all handicapped children from birth to age three and the State Education Agency will assure the provision of such services to all handicapped children from age three through five.	POSITIVE ASPECTS OF OPTION 3.3 • As Gallagher (1979) has pointed out, perhaps if the responsibility were shared, the way would be open to the development of more early intervention policies. • Often where preschool services are offered by the state and localities, these are already provided in this manner, i.e., very early services by human resources, later programs by the SEA, thus maximizing the use of existing services. NEGATIVE ASPECTS OF OPTION 3.3 • Could result in the duplication of services and personnel. • The dual system may be confusing to families, and programming and philosophy may be inconsistent in the birth to three and three through five transition.
OPTION 3.4 LOCAL OPTION Local governments will designate a primary service provider which will assure the provision of appropriate services to all handicapped children birth to school-age within their particular jurisdications.	POSITIVE ASPECTS OF OPTION 3.4 • Often localities are better able to identify the most appropriate provider in their community. • Programs designated in this matter may be more able to reflect local needs, i.e., minority, ethnic, rural/urban characteristics, as well as current available resources and programs.

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
OPTION 3.5 STATE OPTION AND COORDINATION OF SERVICES A sole state agency is designated by the state as responsible for (a) coordinating existing services and developing an annual interagency service plan, and (b) assuring quality of programming.	NEGATIVE ASPECTS OF OPTION 3.4 • May result in a lack of public awareness from one community to another of who the service provider is. • Developing and monitoring standards in order to maintain and guarantee consistency and quality of services may be controversial and difficult to achieve. POSITIVE ASPECTS OF OPTION 3.5 • Coordination of services would prevent duplication and gaps in service and may provide for efficient delivery. • Existing expertise and community awareness of programs would be utilized. • Each state would elect the agency most suited as the responsible sole state agency. NEGATIVE ASPECTS OF OPTION 3.5 • Unless a clear mandate were provided to monitor quality with delineated criteria, consistency of programming would be jeopardized. • Agencies may experience difficulty working cooperatively.

POLICY AREA 4: POLICY NATURE

During the development of P.L. 94-142, Congress amended the original versions of the preschool provisions from mandatory to permissive in nature, while professing the efficacy of early intervention, as evidenced by the comment found in the governing regulations of P.L. 94-142:

> Part 121m--Incentive Grants. Part 121m sets forth the conditions under which States may receive grants to assist in the education of handicapped children aged three through five. Congress established incentive grants in the recognition that when education begins at the earlier stages of development (1) benefits are maximized, (2) additional or more severe handicaps may be prevented, and (3) greater long-term cost effectiveness is realized.

In doing so, Congress "tried to buy what they could not mandate" (CEC, 1979) by providing for the preschool incentive program. In essence, this provision authorizes to states a grant of $300 per three through five year old served. While providing an "incentive" for preschool programming, Congress also, however, provided a disincentive, i.e., the requirement is mandated unless "the requirement would be inconsistent with state law or practice, or the order of any court..." (§121a.122(c)). Thus, a combination of what can be seen as a penalty for having state policy and the failure of the federal government to appropriate the full $300 per child (in fact, only about one-third has been appropriated) has resulted in a drop in the momentum seen in the 1970's in preschool developments. In fact, the recent comparison of state policies in the pre-P.L. 94-142 years to current ones found that more states have lowered or shifted their preschool policies than have expanded (Insight, Vol. 11, No. 6, 1980).

The value to developing a permissive policy may be more procedural than substantive. In other words, a permissive policy may be instituted, not on its own merits, but rather as a prelude to a more mandatory policy. Advocates for early intervention have expressed the hope that the P.L. 94-142 preschool incentive program will move in this direction (Cohen, et.al., 1979). In addition to the nature of the policy, a further decision must be made as to how to make such a policy change, whether through a downward extension of existing school

authority or a creation of a new authority for the preschool-aged population.

The policy options include full mandate, conditional mandate, phase-in mandate, and permissive/incentive.

TABLE 4.
POLICY ALTERNATIVES FOR
MANDATORY AND PERMISSIVE POLICIES

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
POLICY AREA 4. POLICY NATURE	
OPTION 4.1 FULL MANDATE All handicapped children will be assured appropriate early childhood services.	POSITIVE ASPECTS OF OPTION 4.1 • The benefits to children, families and society are fully recognized and uncompromised and the cost-benefit of early intervention will be recognized sooner. NEGATIVE ASPECTS OF OPTION 4.1 • The weaknesses include cost and administrative barriers, as well as requiring new services and systems and in-service training in both attitude and skills. • The personnel needs must be assessed and provision for preservice and in-service training must be made.
OPTION 4.2 CONDITIONAL MANDATE The policy may assure services to a particular group of handicapped children, e.g., certain handicapping conditions or severity.	POSITIVE ASPECTS OF OPTION 4.2 • While providing services to some portion of the population, limits the resources by limiting the population. • May serve to facilitate a more comprehensive mandate at a later date. NEGATIVE ASPECTS OF OPTION 4.2 • The weaknesses include the failure to assure services to all handicapped children and their families. • The ethical and legal issues of the inequity of a conditional mandate. • Conditional mandates that may not raise the same legal issues include mandate by severity, i.e., the most severe or the least severe (depending on rationale) receive the programs, or type of service. An example of a service mandate would be prenatal and neonatal preventive services, such as mother and child health screening, after-care programs, and family services.
OPTION 4.3 PHASE-IN MANDATE The policy will assure appropriate services to increasing portions of the population in designated time periods until reaching a set goal at a particular date or to phase-in a service requirement. Some states have extended their school ages downward periodically, e.g., from six to five to three and eventually to birth.	POSITIVE ASPECTS OF OPTION 4.3 • Gradual public and professional awareness training of the need. • The gradual cost, personnel and systems adjustments to accommodate the new programs. NEGATIVE ASPECTS OF OPTION 4.3 • Ethical issues of ignoring certain age groups, while professing the need for attending to them. • The possibility of the political milieu changing before total phase-in is accomplished, prohibiting full implementation of the goal.

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS
OPTION 4.4 PERMISSIVE/INCENTIVE Appropriate early developmental services may be provided to handicapped children and an incentive will be granted to those providers. Currently, P.L. 94-142 is a prototype of the permissive/incentive option.	POSITIVE ASPECTS OF OPTION 4.4 • Allows providers to assess their capabilities and to participate in the decision making process in delivering early childhood services. • As mentioned before, there are certain detractors to this option related primarily to two factors: (1) As a federal policy which stipulated that it was mandated only for states containing their own mandate, it serves as a disincentive for state policy development. (2) Without full funding, it has not provided the necessary fiscal incentive. Thus, if these factors were remediated, such a policy may not have the same consequences as have been noted in relation to the P.L. 94-142 preschool incentive program. NEGATIVE ASPECTS OF OPTION 4.4 • Unless the incentive was substantial, the likelihood is slim that providers who perceive themselves as overburdened will voluntarily choose to serve a nonmandated population.

POLICY AREA 5: FUNDING AND RESOURCE AVAILABILITY

Recognizing the fiscal implications of assuring services to handicapped children, the framers of P.L. 94-142 provided for mechanisms to allow for the sharing of available resources. These provisions include interagency arrangements for the cooperative delivery of services. Such interagency agreements have helped to prevent duplication of programs and services and have facilitated the utilization of currently available services and expertise. Secondly, while requiring that special education and related services be provided at no cost to the parents, P.L. 94-142 allows for cost sharing and third party payments. P.L. 94-142 regulations (§121a.301(a)(b)) require that:

> (a) Each State may use whatever State, local, Federal and private sources of support are available in the State to meet the requirements of this part. For example, when it is necessary to place a handicapped child in a residential facility, a State could use joint agreements between the agencies involved for sharing the cost of that placement.
>
> (b) Nothing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a handicapped child.

While fiscal implications have been addressed in all the policy areas, the following options relate directly to the issue of funding requirements.

TABLE 5.
POLICY ALTERNATIVES FOR
FUNDING AND RESOURCE AVAILABILITY

POLICY AREAS	POSITIVE AND NEGATIVE ASPECTS

POLICY AREA 5. FUNDING AND RESOURCE AVAILABILITY

OPTION 5.1 SERVICES AT NO COST TO PARENTS

Services will be provided at no cost to parents.

POSITIVE ASPECTS OF OPTION 5.1

- Extends the "at no cost to parents" provision of P.L. 94-142 to preschool-aged handicapped children.
- Assures that all children and their families will be able to access needed services.
- The mechanisms of P.L. 94-142 of interagency agreements, cost sharing and third party payments would be likewise extended for the preschool population.

NEGATIVE ASPECTS OF OPTION 5.1

- Providing services at no cost is the most costly option.
- While the interagency and cost sharing ease the burden of a particular service provider, the majority of the costs are still borne by the public sector.
- Additionally, there have been implementation problems with such mechanisms, particularly third party payments (see Ross, 1980).

OPTION 5.2 SLIDING-SCALE PAYMENT

Services will be provided to children and families on a sliding-scale payment formula, based upon family income.

POSITIVE ASPECTS OF OPTION 5.2

- Providing services on a sliding-scale payment formula lessens the cost to the public sector while assuring that services are available to all handicapped children and their families.
- Families who are considered able to pay will be assessed according to income, while those unable to pay will, nevertheless, receive services.

NEGATIVE ASPECTS OF OPTION 5.2

- Requiring parents to pay for services is contradictory to the positions of some groups, as well as against the intent of P.L. 94-142 as stated in §121a.1 of the regulations:

  The purpose of this part is:
  (a) to insure that all handicapped children have available to them a free appropriate public education...(emphasis added)
- A possible consequence of such a policy would be the creation of parallel programs for different income levels similar to the publicly assisted medical clinics often seen in hospitals.
- Such separate programs might develop in an effort to streamline bookkeeping activities, but could raise serious ethical and legal questions.

CONCLUDING REMARKS

Early intervention for the very young handicapped child and his/her family has been the subject of the attention of researchers and policy makers for the past two decades. As outlined in the Introduction, Congress and state policy makers have systematically approached this area of need with unusual care and forethought. Research supports what advocates believe--it is now time to legislate what we have evidenced to be the benefits of providing developmentally appropriate services to handicapped infants and children and their families at the earliest possible time.

In a recent report of a state-wide analysis of preschool opportunities for the very young exceptional child in Massachusetts, Meisels, Berkeley, and Godfredsen (1980) summarized the state of the art as they see it:

> This report provides evidence to suggest that early intervention service providers and state agency personnel responsible for early intervention are forced to operate in an atmosphere beset by a fragmented policy, by a dearth of overall leadership, and by a lack of awareness by legislators and high level agency officials of the importance of the first three years of life. Responsibility for early intervention is spread among too many agencies in too many different ways with too little administrative, policy, and fiscal direction. (p. iv)

The authors make the following recommendations:

- A lead agency should be established to coordinate services and develop a coordinated public awareness campaign.
- The state should develop standardized data collection and grant application techniques and due process safeguards.
- A full scale financial analysis should be conducted to determine the actual cost and optimal delivery of services.
- The state should enact mandatory early intervention legislation, granting universal access to services.

Policy decisions inevitably have intended and unintended consequences. Intended consequences are often well thought out and planned for. However, concomitant to virtually all political developments are unintended consequences. The Family Impact Seminar of George Washington University has over recent years emphasized the need for policy makers to analyze all consequences of their actions--both intended and unintended--as they affect the family. A similar analysis has been developed in regard to energy, or an energy impact analysis. Such an analysis might be implemented using only those options discussed in this paper.

In addition to studying and analyzing the consequences of particular policy options regarding early childhood services for handicapped children, perhaps an initial consideration for all interested parties is the issue of the lack of available programs and services for the nonhandicapped preschooler. There are many advocates of the benefit of early services for all children and families. Yet, persons who have perceived the need of the handicapped may need to evaluate the consequences of developing public policy assurances only for handicapped young children. Not only may resentment from the nonhandicapped community be encountered, but such policies may inevitably result in segregated programs where handicapped children have no access to their nonhandicapped peers.

These considerations can be weighed against the obvious prohibitive financial and political consequences of attempting to develop early childhood policies for all children. Handicapped policies may be implemented with the intention of phasing-in a broader policy at a later time. The benefits of instituting policies for handicapped children have often had the effect of spilling over to benefit their nonhandicapped peers.

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Position Statement of
The Council for Exceptional Children

Policy:

Schools should provide educational services for individuals according to their needs and regardless of age.

Schools should actively seek out children who may have specialized educational needs in the first years of their lives. A particular commitment should be made to initiate homecare training programs for parents of infants with special needs, to establish specialized nursery school and kindergarten programs, and to utilize specialized components of regular early education programs to serve exceptional children.

From the Policy Statements of The Council for Exceptional Children as established by the CEC Delegate Assembly, pg. 4.

DEC Position Statement on
Services to Handicapped Children Birth Through Five

The Division of Early Childhood of the Council for Exceptional Children believes that the provision of services to handicapped children from birth through five years of age must be made a priority of the 1980's. It is the premise of this division that lack of such services represents the most serious impediment to the development of handicapped children which exists today. There is mounting evidence of the effectiveness of programs for very young handicapped children and their families.*

Services to young handicapped children are currently provided by a variety of systems at national, state and local levels, including public health, social services, education, mental health and specific programs such as Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), Head Start and Child Health Assurance Program (CHAP). There is little systematic coordination between these agencies, and major service gaps remain unfilled. We recommend that a national initiative be made to establish plans for systematic coordination between the social, educational and health agencies currently serving handicapped child birth through 5 so as to insure maximum benefits for these children and their families, and so as to plan for the future provision of additional programs to fill major gaps in service to this population. We urge the Council for Exceptional Children and the Bureau of Education for the Handicapped** to assume leadership roles in bringing about such a national planning effort.

The Division for Early Childhood recognizes that wide variations in service arrangements are necessary to meet the individual needs of children. We strongly support the principle that services for young and handicapped children whenever appropriate be provided in a context which includes nonhandicapped children. Effective integrated experiences can further the development of handicapped children and also can form the roots of respect for diversity in nonhandicapped and handicapped children alike. Since the success of integrated programs relies heavily on the provision of specialized teacher training and supportive resources, we urge that the importance of such supports be reflected in legislative and funding directives.

In expanding services for handicapped children from birth through five years it is essential that the central role of the parent in the young child's development be recognized. The parental role mandated under P.L. 94-142 does not adequately reflect the need for continuous active participation by parents of young children. Programs must be designed to incorporate such participation, and to provide support for families in their role as the child's primary care provider. The training of teachers of young handicapped children should be expanded to include skills in working with parents in mutually helpful ways so that parental and agency efforts in helping the child are strengthened.

*For a review of this evidence see the position paper prepared by INTER-ACT. Contact: Jennie E. Swanson, Ed.D., INTER-ACT, The National Committee for Services to Very Young Children with Special Needs and Their Families, Rte. 1 Box 96C, Barrington, IL 60010.

**Department of Education reorganization title, OFFICE OF SPECIAL EDUCATION.

Approved 4/22/80

Position Statement of
INTER-ACT

Due to the size of the Inter-act document, it has not been included, however, the reference is as follows:

Garland, Corin; Stone, Nancy W.; Swanson, Jennie; Woodruff, Geneva (Eds.). Early Intervention For Children with Special Needs and Their Families: Findings and Recommendations, in press, 1980.

NATIONAL EDUCATION ASSOCIATION RESOLUTION

Early Childhood Programs

The National Education Association urges the enactment of federal legislation to assist state and local communities in providing child care services, including childhood development programs.

The Association believes that implementation of early childhood development programs which have educational components that exceed child care service must utilize appropriately certificated professional educators. It supports those programs which upgrade personnel working in early childhood education and provide for maximum involvement of educators and parents at the operational as well as at the administrative level.

The Association endorses the involvement of minorities and the poor in staffing early childhood programs and also endorses professionally supervised training programs leading to the certification of all personnel. The Association believes that legal certification of professional personnel should remain the function of the states, and objects to federal government intervention in the credentialing process.

The National Education Association urges its affiliates to seek legislation that would insure the implementation of early childhood education programs primarily through the public school system. It believes kindergarten is necessary to the success of early childhood education and supports the concept of mandatory, fully funded kindergarten programs in all states.

The Association advocates the establishment of fully funded preschool special education programs. These programs should be readily accessible, should make available those services necessary to assist handicapped children from birth through five years, and should be staffed with teachers and therapists who are certified by the state.

U.S. Department of Education
Position Statement

In carrying out its duties as conferred by the Congress of the United States, The Department of Education, in its governing regulations for The Education For All Handicapped Children Act of 1975 (P.L. 94-142), states:

> Congress established incentive grants in the recognition that when education begins at the earlier stages of development (1) benefits are maximized, (2) additional or more severe handicaps may be prevented, and (3) greater long-term cost effectiveness is realized.

Policy of the U.S. Bureau of Indian Affairs As Stated In
Their Annual Program Plan for P.L. 94-142, Fiscal Year 1979

RIGHT TO EDUCATION POLICY STATEMENT

It is the policy of the Bureau of Indian Affairs, as mandated by the Deputy Assistant Secretary for Indian Affairs, that all handicapped Indian children ages three through twenty-one enrolled in or eligible for enrollment in schools operated for Indian children, directly or indirectly (through contractual arrangements made with tribal organizations or cooperative arrangements entered into with state or local education agencies) by the Department of the Interior have the right to a free appropriate public education. The definition of handicapped children as it is used in this statement is the definition found at 45 CFR 121a.5 of the Regulations implementing P.L. 94-142. This policy statement applies to all agencies within the Department of the Interior including the Office of Social Services and the Office of Indian Education.

Department of Defense
Office of Dependents Schools

(Proposed, September 1980)

PRESCHOOL PROGRAMS FOR EXCEPTIONAL CHILDREN

1. INTRODUCTION

1. PURPOSE

To provide an individual educational program for preschool, exceptional children who, after identification and assessment by a multidisciplinary team, are determined to require early educational intervention. This early intervention seeks to remediate the child's developmental details while enhancing his/her strengths by providing an appropriate instructional program, on-going evaluation, and continual parental involvement.

The program is based upon the rationale that early intervention will better permit children to more fully attain their potential. Early intervention includes specific educational methods and techniques which seek to remediate developmental deficits while enhancing developmental strengths.

A program goal is for each child to be able to enter a regular school placement, or a least restrictive environment as appropriate for his/her individual needs.

Ages of Eligibility for Special Education
May 1, 1980

State	Law		Regulation		State Plan	
	Ages of Eligibility	Permissive Ages	Ages of Eligibility	Permissive Ages	Ages of Eligibility	Permissive Ages
Alabama	Between 6 and 21			Preschool	6 through 21	3 - D, B, MH
Alaska	At least 3		Legal school age 3 to 19		3 to 19 inclusive	
Arizona	Lawful school age[1]				Between 6 and 21 If K - 5	
Arkansas	Between 6 and 21 If K - 5	Below 6 if SHC			6 and 21 If K - 5	Below school age if SHC
California	Between 3 and 21 C	Younger than 3	4.9 to 21 C	Birth to 4.9[2]	4.9 to 18 with exceptions[3]	Under 3
Colorado	Between 5 and 21	Under 5			Between 5 and 21 C	3 -5
Connecticut	Over 5 under 21	Under 5	School age and preschool		HI - 3 to 21st birthday or C - All others 4 to 21st birthday or C	
Delaware	4 through 20 inclusive		Between 4 and 21 HI & VH - 0 to 21		Between 4 and 21	
Florida*	5	Exceptional children-3 Below 5 D,B Severely PH TMR			13 consecutive years of instruction 5 - 18	0 to 4 18 and above
Georgia	6 to C if K - 5[4]	0 - 5 if SHC necessitates early intervention	Between 5 and 18	0 - 4 If enrolled can continue 19-21	5 to 18	0 to 4 19 to 21
Hawaii	Under 20				9/1/80 Between 3 and 20	
Idaho	School age[5]	To 21	School age Between 5 and 21		Between 6 and 18 inclusive, If K - 5, if 18 and has not graduated through 21	Between birth and 4 or 5 inclusive
Illinois*	Between 3 and 21	0 to 2	Between 3 and 21		9/1/80 Between 3 and 21	
Indiana	Over 6 and under 18	D - 6 mo. 3 to 5 18 to 21	6 to 18	3 through 5 HI - 18 through 21 6 mo.	6 to 18	
Iowa	Under 21		Between birth and 21		9/1/80 Birth through 20	
Kansas	Subject to regulations school age[6]		If K then 5 through 21 C, otherwise 6 through 21 C		Same age as nonhandicapped to school year student reaches 21	Preschool
Kentucky	Under 21		School attendance age persuant to law		5 through 17	Birth to 4 18 to 21

State	Law		Regulation		State Plan	
	Ages of Eligibility	Permissive Ages	Ages of Eligibility	Permissive Ages	Ages of Eligibility	Permissive Ages
Louisiana	3 to 21[7]	Below 3 - Serious handicapping condition	3rd birthday to 22nd birthday		Not less than 3 or more than 21 inclusive	SHC - under 3
Maine	5 to school year student reaches 20. If 2-year K, 4		5 to school year student reaches 20		5 until year reaches 20	
Maryland	As soon as child can benefit and under 21[8]		Birth through 20 - children under 5 will be phased in as required by law		9/1/80 Birth through 20	
Massachusetts	3 through 21		3 through 21 - 3 and 4 year olds must have substantial disabilities[9]		3 through 21	
Michigan	Under 26		Not more than 25 - if turns 26 after enrollment, may complete year		0 through 25 C	
Minnesota	4 to 21	TMR-through school yr. student is 25, if attended public school less than 9 years.	4 to 21		4 to 21	Before 4
Mississippi	6 and under 21	Under 6	Under 21		9/1/80 6 through 20	3 to 5
Missouri	5 and under 21	Under 5	School age	3 and 4	5 through 20	Under 5
Montana	9/1/80 Between 3 and 21	9/1/80 0 to 2	9/80 between 3 and 21		9/1/80 Between 3 and 21 inclusive	0 to 2
Nebraska	From diagnosis to 21		5 to 21 (school age) MH - birth to 21 C		From diagnosis to 21	
Nevada	5 and under 18	MR - 3 G -4 D & VH - under 5			5 or 6 to 18	Outside eligible age range
New Hampshire	3 to 21 C		Up to 21		3 to 21	0 to 3
New Jersey	Between 5 and 20	Under 5 and over 20	Between 5 and 20	Under 5 and over 20	Between 5 and 20	
New Mexico	School age[10]		Legal entry age until age 18	Over 18		
New York	Over 5 and under 21		Under 21		Between 5 and 21[11]	
North Carolina	Between 5 and 18		5 through 17	Birth through 4 18 through 21	Between 5 and 17	Birth to 4 18 to 21
North Dakota	6 and under 21	3 to 6	6 to 21		6 to 21	3 to 6
Ohio*	Between 6 and 18 If K - 5	Other ages	Legal school age		Compulsory school age	
Oklahoma	4		4 eligible for a minimum of 12 years[12]		4 through 18 minimum period of 12 years	19 to 21

State	Law		Regulation		State Plan	
	Ages of Eligibility	Permissive Ages	Ages of Eligibility	Permissive Ages	Ages of Eligibility	Permissive Ages
Oregon	Superintendent establishes eligibility		6 to 21 inclusive If K 5 to 21 If preschool 3 to 21		6 through 20 If K - 5	
Pennsylvania	6 to 21	Below 6	6 to 21 below 6 if regular programs below age 6		Policy is same as regulations and law	
Rhode Island	3 to 21		3 to 21 C		9/1/80 3 to 21	
South Carolina	Lawful school age[13]				Between 6 and 21 HI 4 to 21	
South Dakota	Under 21		Under 21[14]		Under 21	
Tennessee	Between 4 and 21	D - 3	4 through 21 D - 3		4 through 21 D - 3 through 21	
Texas	Between 3 and 21		Between 3 and 21 inclusive. Auditorily, visually handicapped - between birth and 22		Between 3 and 21. Auditorily, between birth and 22	
Utah	Over 5 (if K) under 21		5 through 21		5 through 21	
Vermont	Under 21	Over 21 to C	Under 21		6 to 21 C If K - 5	3 to 5
Virginia	2 and under 21 VH - birth to 21		2 to 21		Between 2 and 21	
Washington	Common school age[15]	Preschool	5 to 21[16]		5 to 21 common school age	3 to 4[17]
West Virginia	Between 5 and 23	3 - 5	Between 5 and 23		Between 5 and 23	
Wisconsin	3 under 21	Under 3	3 to 21		3 to 21	
Wyoming	Over 6 and under 21 If 5 - K		School age		Between 6 and 21 If K - 5	
District of Columbia			Between 3 and 21		9/1/80 Not less than 4 or more than 21. 4 year olds when provided to regular children	

Prepared by the
Policy Research Center
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KEY

K - Kindergarten
C - Completion of Course
D - Deaf
B - Blind
PH - Physically Handicapped
TMR - Trainable Mentally Retarded
HI - Hearing Impaired
VH - Visually Handicapped
MH - Multiple Handicap
MR - Mentally Retarded
G - Gifted
SHC - Serious Handicapping Condition

FOOTNOTES

[1]Arizona - Lawful school age is between 6 and 21.

[2]California - 3-4.9 identified as requiring intensive special education.

[3]California - Exceptions include: 3-4.9 for those identified as requiring intensive services; 19-21 if enrolled before 19 and have not yet completed a course.

[4]Georgia - 3 and 4 year old children who are physically, mentally, or emotionally handicapped or perceptually or lingustically deficient are eligible.

[5]Idaho - Services of public schools are extended to any acceptable person of school age (defined as between 5 and 21).

[6]Kansas - school age is 6 or 5 if kindergarten is available.

[7]Louisiana - Legislation has been passed extending eligibility to 25 in certain circumstances.

[8]Maryland - Effective 7/1/80 Senate Bill No. 734 provides for compensatory education over 21 in certain circumstances.

[9]Massachusetts - Substantial disabilities are defined as intellectual, sensory, emotional or physical factors, cerebral disfunctions, perceptual factors or other specific learning impairments or any combination thereof.

[10]New Mexico - School age is at least 5 and for children in special education a maximum of 21 years of age.

[11]New York - Blind, deaf, or severely physically handicapped children in state schools between 3 and 21. Deaf children less than 3 years of age in approved educational facilities.

[12]Oklahoma - No set minimum age is specified for blind and partially blind, deaf, hard of hearing, or low incidence severely multiple handicapped children.

[13]South Carolina - Lawful school age is over 5 and under 21.

[14]South Dakota - Programs for children under the age of 3 years shall be provided only to those children who are in need of prolonged assistance.

[15]Washington - Common school age is between 5 and 21.

[16]Washington - 0 to 1 and 1 and 2 year old children with multiple handicaps, gross motor impairment, sensory impairment, moderate or severe mental retardation are eligible for services.

[17]Washington - Services are permissive for children 0-2 if they have a multiple handicap, gross motor impairment, sensory impairment, or moderate or severe mental retardation.

COMMENTS

*Florida - According to Florida State Department of Education officials, there is no maximum school age.

*Ohio - According to Ohio State Department of Education officials, Ohio's mandated age range is 5 through 21.

*Illinois - Permissive ages are listed in § 10-22-38 rather than in Special Education Law.